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ABSTRACT

Residential/group child care in the United States was established more than a century ago with permanency planning emerging in the 1970's. Even though there are many beneficial reasons to promote and participate in permanency planning, participation has often been difficult in a rural state. This paper describes a residential child care provider's efforts to increase family based services. Project data determined residential child care providers, youth in care, and family participation in permanency planning meetings within North Dakota. Results indicated residential child care providers and children in care participated in 30% of all permanency planning meetings in the state. Permanency planning meetings were attended primarily when they were conducted within a 30 mile radius of the agency. Factors affecting provider participation at permanency planning meetings included: time management; conflicting responsibilities; distance; lack of sufficient notification; and costs and expenses. As a result of the findings, a proposal was made for using conference calling as a way of increasing the provider participation in permanency planning meetings. Although face-to-face participation is desirable, conference calling could alleviate many of the factors affecting participation. (JE)

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SURVEYING RESIDENTIAL TREATMENT CENTERS, CLIENT, AND FAMILY INVOLVEMENT IN PERMANENCY PLANNING AND EXAMINING ALTERNATIVES TO INCREASE INVOLVEMENT

by

James (Jim) Vitko

Cohort 62

A Practicum Report Presented to the
Master's Program in Child Care, Youth Care, and Family Support
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for the Degree of Master of Science

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11/23/94
Date

Signature of Student

Abstract

Surveying residential treatment centers, client, and family involvement in permanency planning and examining alternatives to increase involvement. Vitko, James A., 1994: Practicum Report, Nova University, Master's Program for Child Care, Youth Care, and Family Support. Descriptors: Permanency Planning/Permanency Planning Involvement/ Residential Child Care/Family Centered Services/Multisystem Interaction/Client Involvement/Parental Involvement/Group Foster Care/Family Preservation/Case Management/Child Welfare/Social Support/Case Work Planning/Human Service Coordination/Human Service Meetings.

This author examined a residential child care provider's efforts to increase family based services. The pro-family philosophy is drawn from Public Law 96-272. This law has set the foundation for permanency planning nationwide. Although permanency planning and residential child care have different origins, both share a common philosophy and an important role in joining and unifying their resources to assist and support children and families.

As a result of the scope and focus of the project, the practicum extended to examining other residential child care providers and permanency planning assemblies in North Dakota. Specifically, the project data determined residential child care providers, youth in care, and family participation in permanency planning meetings conducted in a rural spacious state. Factors including time-management, conflicting responsibilities, distance, lack of sufficient notification, and costs and expenses were identified in influencing involvement in permanency planning meetings. An assortment of data collected was used to examine the magnitude of the problem and set the foundation for proposed solution strategies to benefit the practicum setting, other residential child care providers, permanency planning committees (Department of Human Services), and especially, the children and families in the child welfare system.

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Chapter One

Introduction and Background

The Setting in Which the Problem Occurs

The setting from which this practicum project was developed, implemented, and evaluated, originated from a residential child care provider attempting to promote and improve family based services. Because of the scope and focus of this project, the practicum extended beyond the primary setting, examining other residential care providers and permanency planning assemblies in North Dakota. As a result, the practicum project required the cooperation and coordinated efforts of several organizations and/or settings in the state of North Dakota.

The primary practicum setting from which this project was initiated was a private, not-for-profit residential child care facility (RCCF), residential treatment center (RTC) and special education center for emotionally disturbed adolescent males. The agency was initially established in 1952 and is owned and operated by congregations of the Lutheran Church-Missouri Synod (LCMS). It is licensed as both a residential child care facility and residential treatment center by the North Dakota Department of Human Services and adheres to the Ethical standards of the National

Association of Homes and Services for Children and Council of Accreditation. The agency's school is also accredited and includes a certified Vocational Special Needs Program.

The agency operates in a rural and spacious state. It is located on a 200 acre campus consisting of an extensive, modern complex of facilities. Included are five cottages, a chapel, gym, recreation fields, guest and family apartments, and an educational center which additionally has an industrial arts complex, library, and a computer classroom. Three transitional living apartments are also available for boys who are nearing emancipation.

The agency has a licensed capacity of 56 boys, who typically range in age from 10 to 17. Admission to the agency is based upon one or a combination of the following disorders:

1. Emotionally/behaviorally disturbed behavior patterns. (Such behavior may range from aggressive to extremely passive and withdrawn, but does not conform with the expectations of home, school, and/or community.)
2. Drug and/or alcohol usage that ranges from abuse to addiction. However, the agency will not accept any client whose primary

diagnosis is chemical dependent and in need of inpatient drug treatment.

3. History of failures and nonachievement in school due to behavioral/emotional disturbances and/or learning disabilities.

Referrals are received from parents, juvenile probation, child welfare, mental health services, the Division of Juvenile Services, and special education districts. Boys are accepted from throughout the United States regardless of race or religious creed. However, most placements are in-state residents, with the Division of Juvenile Services being the predominant referral source. Presently, of the children on campus, 81% are placed by the Division of Juvenile Services, 16% are placed by county social services, and 3% are placed by another agency and/or family. Funding sources include foster care maintenance, Medicaid, health insurance, and private pay.

The specialized treatment programs/services provided on-site include: treatment for sexual offenders, children of alcoholism group, chemical dependency awareness groups, aftercare addiction programming, situational decision making group processes, religious services, individual

therapy, psychiatric services, psychological services, family therapy, group therapy, sexual victim therapy, behavioral management programs and therapy, therapeutic recreation, independent living services, medical and dietary services, and educational services with specialties in the areas of emotional disturbance and specific learning disabilities. The identified programs and treatment services result in the agency's employment of over 105 full-time positions, not including contracted and part-time staff.

The agency's original purpose in 1952 was to "provide a home and Christian education for juvenile boys who come from broken homes or who are juvenile delinquents or who are maladjusted in their homes and/or community." The agency operated within the boundaries of this mission for the next three decades. During this time most interventions and treatment efforts focused almost entirely on the child in care and, what I would refer to as, individual oriented treatment. Changes in the social service programs and educational services resulted in the center's current mission stating "the agency is to participate in the healing ministry of Jesus by offering quality residential services and programs to foster the spiritual, physical, psychological, educational, social, and emotional well-being of adolescents and their families, all within the context of the Christian community."

At the present time a new mission statement is being proposed and efforts are directed at family centered services and family preservation becoming the foundation to all the aforementioned services. The proposed mission statement is:

-The agency is committed to providing appropriate services for children and families by:

-seeing the child in the context of the family and the family in context of its surroundings.

The agency's programs are designed for the child as part of the family system and for the family system as a part of their neighborhood and community.

The agency's programs are flexible and responsive, and built on relationships of trust and respect.

The agency's programs are based on the beliefs of empowering families and recognizing their strengths.

-actively promoting and supporting a fully integrated spectrum of services for children and their families.

-establishing clear outcomes which demonstrate efficiency and effectiveness.

Because of the mission and the role that the agency is adopting, it is attempting and/or searching for ways to involve and make children, families, and the community, partners in its endeavors. Efforts are to join and work with all participants, rather than only treating the child. The results are increased awareness and interaction with the external environment.

This leads to details and elements regarding the external environment in which the agency operates. Some particulars include:

-The primary practicum setting considers itself a leader of the licensed residential child care agencies, based on the efforts directed towards family centered services. However, it is representative of 13 residential or group child care agencies licensed by the state. Eight of the operating facilities are licensed for residential child care, while five are licensed as residential treatment centers. A residential child care facility is defined by the North Dakota Century Code 50-11-00.1 as a facility other than an occupied private residence providing substitute parental child care (foster care) to more than eight unrelated children. Foster care pertains to those children who are in need of care for which the child's parent, guardian, or custodian

is unable, neglects, or refuses to provide food, shelter, security and safety, guidance and comfort on a 24 hour basis. Whereas, a residential treatment center is defined by the North Dakota Century Code, section 25-03.2-01 as a 24 hour a day program under clinical supervision of a mental health professional for active treatment of mentally ill persons. A residential treatment center means a facility or part of a facility that provides to children and adolescents, a total twenty-four-hour therapeutic environment integrating group living, educational services, clinical based programs based upon a comprehensive, interdisciplinary clinical assessment, and an individualized treatment plan that meets the needs of the child and family.

-Since the mid-1980's, state and private sources have enhanced an assortment of community based services for at-risk youth and families. The services included: tracking services, respite services, assessments, risk and classification standards, day treatment programs, state-wide shelter care and attended care services which prevented the jailing of youth, detention units, diversified occupational/educational programs, therapeutic foster care, long-term family foster care programs for high-risk youth, family preservation

programs, parent support and education, and intensive in-home family counseling programs. The results of increased community based services are that they may prevent residential placement, but also provide a greater range of aftercare services when the child returns to his family and community.

-The state contains 53 counties which are organized into eight regions. In each region there are regional human service centers and Division of Juvenile Service offices. The eight regional human service centers operate under the Department of Human Services at the State Capitol (North Dakota State Directory, 1994). The eight Division of Juvenile Service offices are managed by the central office of the Department of Corrections and Rehabilitation.

-Permanency Planning Committees are a key element in the foster care system. The committees assure that children in residential foster care and treatment are getting appropriate care. Additional goals include preventive, reunification, and goals of permanence for a child. The permanency planning committees are governed by the Department of Human Services and directed by a regional supervisor from one of the eight regional human service centers. Permanency planning meetings are mandatory, multi-agency, multidisciplinary

committees which review foster care placements of children.

-The licensing state is considered rural as The 1994 World Almanac indicated that it covers 70,665 square miles, ranking 17 in size. The state has 635,927 residents, ranking 47 in population (Eiger, 1993, p. 648). As a result of North Dakota being a rural state, some children who are placed in residential care are extended distances from their family and community.

Role in the Setting

The author joined the practicum agency in 1990 maintaining the primary role of case manager/therapist. Additional responsibilities include designee to the program or associate director, family centered curriculums trainer, and the social service representative on the quality assurance committee.

-The role of case manager/therapist results in direct involvement and coordination of efforts with clients, families, referral sources, permanency planning committees, and other significant people or agencies. Concentrated efforts are directed towards accomplishing endorsed treatment goals. This position sustains a primary capacity in fostering the agency's mission and family centered philosophy.

-The responsibility of partaking in family centered instruction results in direct involvement and training of staff from all agency components and programs.

-The quality assurance program and activities concentrate and demonstrate the program effectiveness to the clients (children and families), customers, and accrediting bodies insuring that the agency's stated mission is accomplished.

It is important to note that, resulting from the position of case manager/therapist, the author has had the opportunity to interact with permanency planning bodies from all regions of the state.

Since 1982, the author has accumulated a diversity of experiences and maintained different capacities in the state's child welfare system. The experiences have resulted in an increased awareness and understanding of the external environment. Positions have included:

-Working as a probation officer in the juvenile court system of North Dakota.

-Serving as a live-in residential child care counselor in a private long-term care facility assisting deprived, neglected, unruly, and

delinquent youth in the foster care system.

-Working as a supervisor in a private short-term treatment setting for adolescents, overseeing and coordinating admissions, activities, and ongoing clinical treatment programs.

-Facilitating the establishment and responsibilities of a regional Division of Juvenile Service office. Providing and coordinating services for unruly and delinquent children committed to the agency's care and under the interstate compact. Responsibilities required collaboration with agencies and committees including: juvenile courts, human services, social services, law enforcement, private agencies, child care facilities and permanency planning committees in Region II.

-As previously identified, the author currently fulfills the role and responsibilities of case manager/therapist, designee to program or associate director, family centered curriculums trainer, and the social service representative on the quality assurance committee at the primary practicum setting.

Chapter Two

STUDY OF THE PROBLEM

Problem Statement

Residential/group child care in the United States was established more than a century ago with permanency planning materializing in the 1970's. Although they have different origins and continue to evolve, both have shared an important role in joining and unifying their resources to assist and support children and families. Based on the changing roles and/or mission of residential child care agencies (especially in the primary practicum setting), federal regulations, accreditation standards, state guidelines, the importance of coordinating case plans, and the value of involving all participants in planning, permanency planning possesses the components that can be advantageous and valuable to the child, family, and residential child care provider. Even though there are many beneficial reasons to promote and participate in permanency planning, participation often has been difficult in a rural state and has been inconsistent from the primary practicum agency. Based on this author's previous work experiences in child welfare, this problem also appeared to extend to the other 12 residential child care agencies within the state. Therefore, the problem being identified assessed involvement and/or the potential lack of

involvement of children in residential care, parents, and residential child care providers in permanency planning meetings.

Documentation of the Problem

The primary practicum setting has strived to fulfill a mission to: Provide appropriate services for children and families by seeing the child in the context of the family and the family in the context of its surroundings and designing programs for the child as part of the family system and for the family system as a part of their neighborhood and community. The programs are based on the beliefs of empowering families and actively promoting and supporting a fully integrated spectrum of services for children and their families.

In the agency's staff training program, the training curriculum asserts that the family of every child in placement is an irremovable part of his life, irrespective of external circumstances. Children grow up healthiest when they grow up in a stable and nurturing family system. The focus of residential care is to strengthen and restore family relationships. The family is the most important system that anyone will ever experience. Therefore, the child and the family are both the client of the agency. If the child does

not have a home to return to, the goal is to provide the child with a permanent tie to a caring adult, not an institution. Children need to have an ongoing relationship to a family system, not an agency or institution. Each child and family has the right to participate in a comprehensive plan that defines goals to be achieved. This serves as a guide to the families, youth, and professionals who work together (Alwon, Budlong, Clark, Holden, Holden, Kuhn, & Mooney, 1988).

Not only is the family a system, but all the involved participants and agencies create a system. The challenge has been not only to support the family system, but to effectively work together as a team providing services to the family. For effective service delivery, all aspects of the system need to be involved and understood (Alwon, et al., 1988, pp. I-12).

With the recognition of these concepts, the practicum setting has begun to develop increased activities and services directed towards the mission, and continues to strive towards enhancing the family centered services. Vast improvements and communication with families and referral agencies seem to be occurring since the efforts have been directed towards the mission. However, one of the greatest challenges in a rural state has

been the interaction of the entire system and the task of interacting with the family system as a part of their neighborhood and community. This can be difficult based on the fact that families, communities, and referral sources can be great distances from the child and the residential center. An additional factor that resulted in complications has been the coordinating of participants with diverse schedules.

Currently, the practicum setting has 56 boys who come from 25 different communities spread across the state. This is constantly changing and different communities and components may be drawn into consideration with each new placement.

However, there is a component that exists that is homogeneous in all of the 56 aforementioned foster care placements at the primary practicum setting. The component identified is an established instrument or assembly that pulls together all the participants of the entire system, including the child, family, residential service provider, court appointed custodian, and the vast array of support and community services. This assembly of permanency planning has been established across the entire state. Permanency planning possesses the infrastructure to foster the

aforementioned ambition of the systems being involved and better understood. Rather than the practicum setting directing energy to devise a similar system, it seems logical to access and promote a system that has already been established.

The North Dakota Department of Human Services Manual (1990) indicates permanency planning for children is based on the concept that every child is entitled to a permanent home and the purpose of the permanency planning committee is to insure that children are receiving appropriate care consistent with permanency planning philosophy, rules, and to fulfill the requirements of Federal Public Law 96-272. (Further examination of permanency planning philosophy and Federal Public Law 96-272 will be reviewed in the analysis of the problem.) Permanency planning committees are a key ingredient in the implementation of permanency planning in foster care. The permanency planning committees are mandatory and are multi-agency, multidisciplinary committees which review foster care placements. The meetings are conducted in group face-to-face committee meetings, telephone conference calls, or a combination of the two (North Dakota Department of Human Services Manual, 1990, p. 20).

Those who participate continuously on permanency planning committees include the regional foster care supervisor and county social service board director or designee. Recommended permanent members may include, but are not limited to:

-A treatment or therapy person

-Juvenile court supervisor or other court representation

-Tribal Government personnel (where appropriate)

-Case manager (includes Division of Juvenile Services representative)

Members of the committee on a case specific basis may include:

-Parents or legal guardian

-Foster parent

-Foster child

-School official

-Others having interest in the child and/or family

-Group home or residential child care facility

The natural parents/guardian, foster child(ren) (where appropriate) must be invited to participate in permanency planning unless good cause exists to exclude any person from the planning meeting (North Dakota Department of Human Services Manual, 1990, pp. 12-13).

North Dakota Human Service Department permanency planning policy and procedures (1990, p. 14) specify that:

> -The placement plan of every child in care less than two years should have a complete committee review every three months.
>
> -Under the law the child's status must be reviewed no less frequently than every six months. The review must be conducted by a panel or a committee of appropriate persons.

With the identified participants and meetings being conducted typically every three months in the community from which the child is or has been affiliated, the meetings are or can be supportive of keeping the child, family, and residential provider interacting and planning with the entire system. As a result, the entire system is better involved and understood resulting in benefits for all participants.

Based on the outlined materials, participation in permanency planning would be regarded as an essential component to join all the systems together. Yet, participation in permanency planning meetings has been very inconsistent. Based on this author's observations, permanency planning meetings have been attended primarily when they are conducted

within a 30 mile radius of the agency. The attendance of permanency planning meetings any distance over 30 miles from the practicum setting seldom occurs. Again, the North Dakota Department of Human Services Manual (1990) indicated telephone conference calls are an alternative for participation. However, it is important to stress that sites where permanency planning is conducted do not have conference call systems.

During my employment as a Division of Juvenile Services case manager, I was responsible to conduct permanency planning reviews on all of the foster care placements from the region I directed. This included all children in residential child care. Similar patterns were observed as attendance of permanency planning meetings varied and occurred when the child, family, and/or residential provider was in close proximity of the meeting. Conference call systems were not available at the sites where I was required to conduct my permanency planning reviews.

It could be indicated that a reason for lack of attendance may be based on the permanency planning meetings not being worthwhile. Although this may be a reason for not attending, this has not been an explanation that has been collected for lack of participation. The reasons

that employees at the practicum setting have provided for irregular participation are similar to the explanation that was collected from other residential child care providers for lack of attendance during my experiences with the Division of Juvenile Services. These reasons included:

-Time management problems - The amount of time to travel across or throughout the state was not feasible with the assortment of other responsibilities.

-Conflicting requirements - Children have school and residential staff may have conflicting meetings and responsibilities. Permanency planning meetings are conducted during the weekday conflicting with family work schedules.

-Distance - The travel distance to attend a permanency planning meeting was too great. An agency representative could travel up to ten hours by automobile to attend a meeting that will generally last 30 minutes to one hour in length.

-Lack of sufficient notification - Insufficient notification of permanency planning meetings was also identified as a problem. When this occurs, there may be conflicting appointments and inadequate time to prepare for attendance.

-Costs and expenses - When a meeting was conducted a distance

from the residential setting there were significant costs that occurred including transportation, lodging, and the expenses for two staff to transport the child while traveling. Based on staffing patterns, interference with supervision of the remaining children may occur.

The literature search resulted in no information being available pertaining to specific data surveying and/or examining child, family, and residential child care provider participation in permanency planning processes. Many of the writings of permanency planning operate under the assumption that the identified participants are included in the process. If we are assuming that participation of the child, family, and residential provider is occurring, we may be assuming wrong and our assumptions may be jeopardizing an important link with the community and the entire system. In the analysis of the problem, the literature search shared findings supporting involvement as being instrumental to the process and to accomplish goals.

Up to this point the concept that permanency planning involvement is insufficient was based on personal observation and impressions. The reasons why permanency planning attendance may be lacking was also

based on assumptions. There was no data available in regards to the residential child care provider, children in residential centers, and/or family member participation in permanency planning meetings. Furthermore, there was no information that scrutinized factors pertaining to involvement of North Dakota's residential child care providers participation in permanency planning. Even though there was a common ideology promoted by both the primary practicum setting and the permanency planning bodies, there was no information available to support and/or determine the above observations. To improve family centered residential services and the permanency planning process, this area of examination and confirmation was necessary to advance services in the child welfare system and to overcome systems barriers if they exist.

Analysis of the Problem

The enactment of Public Law 96-272, the Adoption Assistance and Child Welfare Act of 1980, had significant implications on major shifts in child welfare policy. Public Law 96-272 has been essentially a pro-family law (McGowan & Meezan, 1983) and the passage of the law helped fulfill the permanency planning movement across the nation (Gibson & Noble, 1991). The concept of permanency planning has undergone a process of

revision and redefinition since its emergence (Maluccio, Fein, & Olmstead, 1986).

There is no universally accepted definition of permanency planning (Miller, Fein, Bishop, Stilwell, & Murray, 1984). In the 1970's, the concepts of permanency planning focused attention on three major issues: (a) the unnecessary removal of children from their biological parents, (b) the lack of effort to maintain contact between children removed from the home and biological parents, and (c) the frequent movement of children from one out-of-home placement to another (Cox & Cox, 1985). Other views were more operations oriented. Stein (1981) described permanency planning as a systematic process of gathering and using information, making informed decisions, formulating case plans, and providing problem-solving services. A definition frequently alluded to is: "Permanency planning is the systematic process of carrying out, within a brief time-limited period, a set of goal directed activities designed to help children live in families that offer continuity of relationships with nurturing parents or caretakers and the opportunity to establish life-time relationships" (Maluccio & Fein 1983, p. 197).

Although different definitions have been provided since its origin, Maluccio, Fein, and Olmstead (1986, pp. 15-16) have taken the aforementioned concepts and described permanency planning to have the following features:

- a philosophy highlighting the importance of the biological family and the value of rearing children in a family setting;
- a theoretical perspective stressing that stability and continuity of relationships promote a child's growth and functioning;
- a program focusing on systematic planning within specified time frames for children who are in care or at risk of placement out of their homes;
- a case management method emphasizing practice strategies such as case reviews, contracting, and decision-making, along with active participation of parents in the helping process; and
- active collaboration among various community agencies, child care personnel, lawyers, judges and others working with children and their parents.

These features and the requirements of Public Law 96-272 have set the foundation for permanency planning and the permanency planning committee in North Dakota. As a result, the permanency planning

philosophy has been identified as the cornerstone for the delivery of services in the Foster Care for Children Program in North Dakota (North Dakota Department of Human Services Manual, 1990, p. 2).

The positive results of permanency planning and legislative initiatives has been the direct involvement and the systematic participation of parents in children's treatment and aftercare processes (Blumenthal & Weinberg, 1984). The legislation and permanency planning philosophy have also had significant impact on residential child care settings. Originally, permanency planning was conceived as a strategy most appropriate to foster family care, but in the early 1980's it was determined to be an effective method of working with children placed in residential facilities (Maluccio, Fein, Hamilton, Klein, & Ward, 1980). According to Jenson and Whittaker (1987), the language and intent of the law encouraged residential facilities to shift their focus from child centered care to family care. Historically, residential child care programs have concentrated on the child in placement with little regard for the parents' ability to assist in the treatment and further identify the disregard for the community reentry process (Laird, 1979; Letulle, 1979).

Laird (1979) stressed the importance of the biological family in the

child's life and that human attachment should be a concentration in child welfare practice. Major reforms in the child welfare policy have motivated residential facilities to develop strategies that actively involve parents in phases of care. These changes are being identified as "family based (Jenson & Whittaker, 1989) and/or family centered services." Residential facilities have begun to view treatment services as temporary interventions that must incorporate elements of a child's home and community life into the treatment process in order to provide effective care (Ainsworth & Fulcher, 1981; Anglin, 1985).

In cases where there has been limited involvement of the parents in residential care, Whittaker (1979,1981) identified a number of factors as a cause. These include: (a) lack of financial resources to provide family services to parents for children in care; (b) location of treatment facilities in rural or isolated areas; (c) sociocultural differences between treatment personnel and parents; (d) limited roles offered to parents of children placed in treatment facilities; (e) parental attitudes of personal guilt for the inappropriate behavior exhibited by their child; (f) parental fears of continued failure in efforts to change their child's behavior; and (g) multiple problems, such as inadequate finances, family disorganization, and legal

difficulties, facing families of children placed in residential care. It is important the residential providers continue to enhance the services offered to children and families. Efforts also must be directed at resolving the factors that result in limited involvement.

However, residential facilities must improve their relationships and strengthen linkages to communities (Jenson & Whittaker, 1989). Professionals in residential care will be spending less time in direct treatment of children and more time working with and through the environment, particularly in creating and/or maintaining social support networks for children and their families (Whittaker, 1979; Whittaker & Garbarino, 1983). McGowan and Meezan (1983) noted that if Public Law 96-272 was to be well implemented, close linkages among traditionally distinct components of the child welfare system must be developed (McGowan & Meezan, 1983).

As Finkelstein (1988) affirms, the challenge to residential care is to understand its mission. Residential care can no longer provide for the here-and-now situation in the institutional environment and managing children's behaviors. It is important to coordinate efforts and build the foundations to

make connections to help young adults. Alliances need to be made with permanency planning bodies. While connections can be initiated with the family on the residential site, they must extend to the community of the family.

At the time of discharge from residential care, there are several important determinants of a child's long-term adjustment. Such factors include the availability of support from family and peer networks and the presence of supportive environments in school and the community (Coates, Miller, & Ohlin, 1978; Montgomery & Van Fleet, 1978). It has been shown that an awareness of the importance of permanency planning does help in moving children from temporary care back to their biological homes or to adoptive homes (Lahti, Green, Emlen, Zendry, Clarkson, Kuehnel, & Casciato 1978; Sisto, 1980). It was found that children leaving residential treatment centers with supportive community ties to family, friends, neighbors, schools, and the like were more likely to maintain their treatment gains than those who did not have this support. Those with support maintained 70 percent of their gains, while those without support maintained only 50 percent (Nelson, Singer, & Johnsen, 1978).

But as identified by Krueger (1990), planning for discharge begins on the first day a child (and family) enters residential care. Therefore, permanency planning and permanency planning committee involvement is not initiated as a child nears discharge from residential care, but the committee is a vital component of the system throughout the process. For effective service delivery, all aspects of the system need to be involved and understood (Alwon, et al., 1988, pp. I-12).

Although residential child care and permanency planning have different origins, both as social movements have much in common. The two movements can and should become integrated in a cohesive and natural fashion as group child care can play a powerful role within a permanency planning framework (Maluccio, 1988, p. 13). Group child care should promote the values and goals of permanency planning; and permanency planning can enhance the contribution of group child care to children and families (Maluccio, 1988, p. 21).

The importance of collaboration between residential child care providers and permanency planning committees has been further supported by findings that the involvement resulted in the sharing of information,

raising energy levels, facilitating case resolution, and increasing respect each group had for the other (Miller, Fein, Bishop, & Murray, 1985).

Beyond residential child care and permanency planning committees, it was vital not to overlook the significance of the family and child's involvement. Permanency planning as a process may be described as a macro system or macro intervention from the perspective that it takes on a role of coordinating efforts of organizations and communities. But permanency planning should also be considered a micro system or micro intervention. A micro intervention is a social treatment with a goal to alleviate social problems for an individual and/or family (Whittaker, 1974). When viewing the process as a micro intervention, it is important that the family and child be involved. In examining supportive efforts directed at the resolution of individual and family problems, including collateral actions, the participation of the child and/or family is vital.

Parents must become full partners in the helping process (Whittaker & Garbarino, 1983). Within permanency planning programs are techniques or methods emphasizing specific responsibilities, contracts, service agreements with parents, time deadlines, and the goals to accomplish the

plan. Through active involvement in the helping process, parents can better understand what is needed for the child to be able to return and stay home (Maluccio & Fein, 1983). In intervention teams, parents and other family members are essential members of the team (Caires & Weil, 1985). Cimmarusti (1992) indicated that the best interests of the child cannot be represented without involving the child's family.

The same has been true in regards to the child's participation in the meetings. As indicated, permanency planning programs emphasize specific responsibilities, roles, time deadlines, and the goals to accomplish the plan. Through active involvement in the process, the child can better understand his role and continue to feel connected with the process and his community. A vision is effective only if it is shared by those who are necessary to its implementation (Garner,1989, p. 19).

Based on the above facts which outlined the significance of permanency planning, the changing role and mission of residential child care agencies (especially in the primary practicum setting), federal regulations (Public Law 96-272), state guidelines, the importance of coordinating case plans, the significance of children maintaining supportive

ties with their family, school and community, and the value of involving all participants in planning, it is essential that children in residential care, families, and residential child care providers participate in the permanency planning process and meetings. However, is this occurring and what are the significant obstacles that may be interfering?

Chapter Three

Goals and Objectives

Goals

The goal of this activity was to obtain unbiased and valid data to determine children in residential care, families, and residential child care provider participation in permanency planning meetings within the state. The collected data was used to examine the magnitude of the concern, and set the foundation for proposed solution strategies to benefit the practicum setting, other residential child care providers, permanency planning committees (Department of Human Services), and ultimately benefit the children and families in the child welfare system.

Objectives

Based on the goal statement, by the end of the tenth week the objectives were identified as follows:

1. Collected reliable, unbiased, and valid data that provided an understanding of the percentage of the children in residential care, families, and residential child care providers who participated in permanency planning meetings conducted in North Dakota during the year of 1993.

2. Gathered data identifying the distance between permanency planning meetings and the in-state residential child care placements. Specifically examined if child and provider participation decreases, remains constant, and/or increases based on the distance between the location of the meeting and the location of the residential child care provider.
3. Acquired specific data to compare in-state residential provider participation in permanency planning meetings. Specifically collected information to compare the primary practicum setting in relationship to other in-state residential child care provider participation in permanency planning.
4. Acquired data to compare residential child care provided to family foster care participation in permanency planning meetings.
5. Identified specific expenses, time considerations, and other factors involved with attendance at permanency planning meetings.
6. Gathered data identifying the number of permanency planning sites with speaker phone/conference call capabilities.

Based on the goal statement, objectives that extend beyond the practicum project are identified as follows:

7. Based on objectives one through five of the practicum project, the findings and solution strategy will be provided at the primary practicum setting to the social service and quality assurance committee.

8. Based on objectives one through five of the practicum project, the results of this project, the findings, and solution strategy will be provided to the Department of Human Services, Children and Family Services Division.

9. Based on objectives one through five of the practicum project, the results of this project, the findings, and solution strategy will be presented to North Dakota's Coalition of Residential Providers.

Chapter Four

Solution Strategy

Existing Programs, Models, and Approaches

Because of the nature of the practicum and practicum goals, the literature review did not result in analogous information being obtained to identify corresponding studies relevant to North Dakota and/or solution strategies. The literature review resulted in an assortment of supportive findings with common themes, concerns, and/or important related factors in the permanency planning process. Some of these included the important features of permanency planning (Maluccio et al., 1986), the significance of collaborative efforts (permanency planning and residential collaboration) (Maluccio, 1988; Maluccio & Fein, 1983, p. 199; Miller, et al., 1985; Miller, et al., 1984), parent and family involvement in the permanency planning process (Whittaker & Garbarino, 1983; Maluccio & Fein, 1983; Caires & Weil, 1985), and benefits to the child's long-term adjustment (Coates, et al., 1978; Montgomery & Van Fleet, 1978; Lahti, et al., 1978; Sisto, 1980; Nelson et al., 1978).

As outlined earlier, the North Dakota Department of Human Services Manual (1990) indicates the purpose of the permanency planning committee

is to insure that children are receiving appropriate care consistent with permanency planning philosophy, rules, and to fulfill the requirements of Federal Public Law 96-272. The permanency planning committees are mandatory and are multi-agency, multidisciplinary committees which review foster care placements. The meetings are conducted in group face-to-face committee meetings, telephone conference calls, or a combination of the two (North Dakota Department of Human Services Manual, 1990, p. 20), with a complete review occurring every three or six months dependent on the amount of time the child is in care. The natural parents/guardian, foster child(ren) (where appropriate) must be invited to participate in permanency planning (North Dakota Department of Human Services Manual, 1990, pp. 12-14). However, no data was available examining the identified practicum goal and objectives.

Many of the writings in the literature review distinguished the importance of engaging the parents and clients into the helping process (Hollis & Woods, 1982; Shulman, 1984; Gambrill, 1983; Mishne, 1983). Although there was resemblance to this practicum project, there was also a difference as those identified in the literature review discussed principles and techniques that applied to casework. In this project, the primary focus

concentrated on involvement and identified elements that may interfere with involvement in the permanency planning process. Some of the previously identified possibilities included time management problems, conflicting responsibilities, distance interference in a rural state, lack of sufficient notification, and related costs and expenses.

The solution strategies were clearly limited and influenced by the goals and objectives in the project. Collection and an examination of data were identified to be critical in assessing the problem and accomplishing the goal. Considered ruled-out solution strategies included:

1. Examining the primary practicum setting's client case records, reviewing narratives and/or completed permanency planning reports to calculate child, family, and agency attendance at permanency planning meetings.

   The reviewing of agency records could have resulted in reliable and valid data in regards to the agency and its current population. However, because the surveyed population was limited to only the practicum setting, reliable, unbiased, and valid data would not have been obtained in regards to the identified goals and objectives. No understanding of other

residential providers' participation in permanency planning would have been obtained and the proposed solutions would have been solely based on the practicum setting.

2. To conduct a survey method of residential providers gathering observations and opinions surrounding their (or lack of) participation in permanency planning. Options included a survey or interview process.

Numerous concerns were identified with this process. The information collected would have been biased and solely from the residential provider. The information collected may have been a valid opinion of the residential provider, but again it would have exclusively been an opinion. Concerns were noted over the reliability of the information and the lack of statistical data.

Description of Solution Strategy

Leedy (1989, p. 3) indicated in Practical Research: Planning and Design, "Everywhere our knowledge is incomplete and problems are waiting to be solved. We address the void in our knowledge by seeking answers

to them. The role of the research is to provide a method for obtaining those answers."

The implemented solution strategy involved the cooperation and coordinated efforts of several organizations and/or settings in the state of North Dakota. The selected solution strategy collected reliable, unbiased, and valid data providing precise findings pertaining to the first five objectives identified by this author. A different method of data collection was implemented for objective six. After completing objectives one through six, the data was analyzed resulting in proposed/potential solution strategies. Reference should be made to the detailed activities outlined in the plan of implementation (see Appendix D).

Specifically, the selected solution strategy for objectives one, two, three, four, and five required the review of completed 1993 permanency planning initial and progress reports at North Dakota's Human Service Centers. The review examined the previous year's (1993) permanency planning reports/records (see Appendixes A and B) at two of North Dakota's Human Service Centers. A preferred method of collecting data would have been to review a sample from each region. But, based on the time

limitation of this project (ten weeks), coordination requirements with staff and centers, and expenses that were covered by this author, collecting samples from two regions was selected. As indicated earlier, North Dakota's Human Service Centers are homogeneous and are organized or divided into eight regional offices. The examination of permanency planning reports from two regions provided a representative sample of children, family, and residential child care provider participation in permanency planning meetings held in those regions. The two selected regions were located in North Central and Southeastern North Dakota.

The permanency planning reports reviewed at North Central and Southeast Human Service Centers were the Department of Human Service Forms SFN 624-1SS/903 and SFN 624-2SS/902 (see Appendixes A and B). The permanency planning reports are a valid recording instrument for permanency planning, as completion is a federal/state requirement on every child in foster care. The completed permanency planning reports for 1993 are kept on file at the Regional Human Service Center. The permanency planning forms have been designed to incorporate the federal requirements relating to case plans for foster care and they are the records/documents of care review (North Dakota Department of Human Services Manual, 1990,

p. 7). They document attendance of participants involved at the permanency planning meeting. The particular areas of interest on the completed permanency planning forms were:

-Form SFN 624-1SS/902 - reporting areas #6 and/or #14 which determined the residential (foster care) facility; and #19 which determined if the child, residential (foster care) provider, and/or parent was involved in the permanency planning meeting.

-Form SFN 624-2SS/903 - reporting areas #3 and #8 which determined the residential (foster care) facility; and #9 which determined if the child, residential (foster care) provider, and/or parent was involved in the permanency planning meeting.

Information from the above-identified reporting areas was recorded onto a form devised by this author which was used for data abstraction (see Appendix C).

Because of the nature of the project, this author was required to adhere to state law (North Dakota Century Code 75-01-02-02) which outlines confidentiality in research projects. Based on the research resulting in the examination of records under the administration of the North Dakota Department of Human Services, authorization was required.

Approval to examine records was initiated on April 15, 1994, and was acquired from the Director of Management Services, Department of Human Services, on May 10, 1994. Following project approval, the author provided verification and coordinated planning with the two regional center directors and supervisors. The author was the only person involved in the data abstraction process. The data collected respected child and family anonymity.

The identified strategy for objective six required personal contact with eight regional supervisors by phone. The regional supervisors lead the permanency planning meetings held in each of the human service regions and are familiar with each site. The specific information collected by the interview included: 1) the number of permanency planning sites at which the regional supervisor participated in, and 2) which sites had conference call capabilities.

The costs of the solution strategy encompassed expenses such as travel costs for 610 miles (i.e., gas and vehicle upkeep), meals, materials, and two nights of lodging. Leave from work (three days) was also required.

Chapter Five

Strategy Employed

Action Taken and Results

The endeavors of this author to achieve the identified goals and objectives followed the scheme outlined in the solution strategy (Chapter IV) and the calendar of activities (Appendix D). The collection of data from the permanency planning forms at the two human service centers resulted in over 2600 foster care records (files) being reviewed and the securing of information which was beneficial to execute the project goals and objectives. Pertinent information was extracted according to the permanency planning information form (Appendix C) and from Department of Human Service Forms SFN 624-2SS/903 and SFN 624-1SS/902 which were completed in 1993. A total of 620 information forms (Appendix C) were obtained from the 1993 permanency planning meetings (PPM) conducted in the two regions. The 620 information forms were comprised of 287 family foster provided care, 39 out-of-state residential child provided care, and 294 in-state residential child provided care permanency planning meetings. Data was obtained in relationship to ten of the 13 residential child care facilities in North Dakota. The three which did not emerge in findings were small centers that were not accessed by the two regions for

residential services. The preceding information set the foundation of the action that was initiated by this author to accomplish the practicum goals and objectives.

Results for Practicum Goal

The practicum goal: To obtain unbiased and valid data to determine children in residential care, families, and residential child care provider participation in permanency planning meetings within the state. The collected data will be used to examine the magnitude of the concern and will set the foundation for proposed solution strategies to benefit the practicum setting, other residential child care providers, permanency planning committees (Department of Human Services), and ultimately benefit the children and families in the child welfare system.

As the reader reviews the collected results from objectives one through five, the previous identified problems in Chapter two of this report were been substantiated. The participation of residential providers in permanency planning meetings was of concern. The collected data also provided important information to address solution strategies to benefit the

practicum setting, other residential child care providers, permanency planning committees and most importantly the children and their families in the child welfare system. As a result of the findings in this chapter, a portion of the above goal was been accomplished. However, the solution strategy proposed by this author is still necessary. The summarized objectives and results are incorporated into the conclusions and recommendations of this project which resulted in the accomplishment of the practicum goal. The following information are the results acquired for objectives one through six.

Results for Objective One

> Objective One: Collect reliable, unbiased, and valid data that will provide an understanding of the percentage of children in residential care, families, and residential child care providers who participated in permanency planning meetings conducted in North Dakota during the year of 1993.

The information collected from the data abstraction appeared to be advantageous to determine objective one. The data acquired came from a total of 333 samples of residential child care provided permanency planning meetings (PPM's) conducted in the two regions. Of the 333

sample, 294 reviews were from in-state residential child care placements and 39 reviews were from out-of-state residential child care placements. The results are outlined in Table 1 indicating the percent.

Table 1

Summary of Residential Child Care Related 1993 Permanency Planning Meetings

Human Service Center	North Central 150	Southeast 183	Total 333
Participation by:			
Provider	47	54	101
Percentage	(31%)	(30%)	(30%)
Child	43	56	99
Percentage	(29%)	(30%)	(30%)
Parent	59	101	160
Percentage	(39%)	(55%)	(48%)

It is stressed that the results included any permanency planning meeting that was conducted in the region where the child was placed in a residential child care facility. Data in Table 1 does not differentiate participation based on the location of the residential provider in relationship

to the permanency planning meeting. The percentage of participation for the provider and child in both regions was almost identical. However, parent participation in the two regions was not analogous as there was a difference of over 16 percent. Most significant was the fact that only 30 percent of the conducted permanency planning meetings were attended by the provider and/or child in care.

Results for Objective Two

> Objective Two: Gather data identifying the distance between permanency planning meetings and the in-state residential child care placements. Specifically examining if participation (child and provider) decreases, remains constant, and/or increases based on the distance between the location of the meeting and the location of the residential child care provider.

The second objective produced important information. The collection of data resulted in comprehension of the distances that separated residential child care providers from the location of the permanency planning meetings. Figures also demonstrated the correlation between the distance and attendance.

As suspected in a rural state, the distance between the permanency planning meeting and the residential provider was often vast. Seventy-four percent of the residential reviews indicated children (220 out of 294 residential placements) were not placed near their home. The collected data indicated that the distances within the state were as great as 350 miles. In 129 of the 294 in-state residential placements that were reviewed, the distance from the residential site to the permanency planning meeting exceeded 200 miles. The mean/average distance that the in-state residential provider was from the location of the permanency planning meeting (PPM) in 1993 was slightly different between the two surveyed regions. The results were:

-North Central mean distance between the residential provider and the PPM was 115 miles.

-Southeast mean distance between the residential provider and the PPM was 182 miles.

-The average/mean distance between the residential provider and the PPM of the two combined surveyed regions equalled 152 miles.

In Table 2, findings surrounding permanency planning meeting participation and distance are summarized.

Table 2

Summary of In-State Residential Child Care Provider Attendance at 1993 Permanency Planning Meetings Based on Location

	PPM's Within 30 Miles of Residential Center	PPM's Over 30 Miles From Residential Center
Total Number Of Meetings	74	220
Number Attended by :		
Provider Percentage	64 (86%)	35 (16%)
Child Percentage	58 (78%)	39 (17%)

It is important to note that parental participation was not included in Table 2 as data was not collected. Permanency planning meetings are extensively conducted in or near the community where the parents reside. For figures surrounding parental participation, please refer back to Table 1. Please see Appendix E for visual reference.

The findings indicated that attendance of the child and residential provider was significantly different based on the location of the meeting and the location of the residential center. Provider participation decreased by 70 percent and child participation declined 61 percent if the meeting was conducted over 30 miles from the residential center.

Results for Objective Three

> Objective Three: Acquire specific data to compare in-state residential provider participation in permanency planning meetings. Specifically collecting information to compare the primary practicum setting in relationship to other in-state residential child care provider participation in permanency planning.

As previously indicated, data was obtained in relationship to ten of the 13 residential child care facilities in North Dakota. The three which did not emerge in findings were small centers that were not accessed by the two regions for residential services. The collection of data in this goal was incorporated with the permanency planning information form (Appendix c), but the analysis of the results was slightly ambiguous. This was based on

the fact that some of the residential providers were in one of the survey regions, while other providers were not in either. However, by surveying two regions, data was collected on all the in-state providers and their attendance at permanency planning meetings outside of their region. In an effort to justly examine the results, data in this objective has been divided two ways. The first was comparing all the in-state residential providers' attendance at ppm's over 30 miles from their site. The second examination compared attendance of four selected residential providers which were in the same community as the two sites of data abstraction.

In Table 3, attention was directed to the fact that in nine of the ten providers the percentage of attendance of meetings beyond 30 miles did not exceed 25 percent. The exception related to in the center which used conference call interactions to participate.

Table 3

Specific In-State Residential Providers' Attendance at Permanency Planning Meetings Greater Than 30 Miles From the Site

Provider	No. PPM's	No. Attended	% Attended
CHYS	18	2	11%
TDC-F	4	1	25%
TDC-M**	56	13	23%
EYH	5	1	20%
HOTR	57	3	5%
LIT-F	5	5*	100%
LUT-H	8	1	12.5%
PLC	39	2	5%
RIV-E	8	2	25%
RM	20	5	25%

*Indicates that the PPM's were attended by conference call

**Indicates agency affiliated with author

Table 4 examined the attendance of providers when the meeting was conducted near or in the same community as the center.

Table 4

Attendance at Corresponding Sites of In-State Residential Providers and Permanency Planning Meetings

Provider	No. PPM's	No. Attended	% Attended
TDC-F	12	12	100%
TDC-M**	32	30	93%
LUT-H	9	6	66%
RIV-E	19	14	74%

**Indicates agency affiliated with author

Results for Objective Four

Objective Four: Acquire data to compare residential child care provided to family foster care participation in permanency planning meetings.

As previously indicated, 287 of the 620 information forms (Appendix C) collected involved family foster care reviews. The North Central Center accounted for 102 meetings and Southeast provided 185 family foster care permanency planning meetings. The percentage of attendance in the surveyed 1993 family foster care permanency planning meetings totaled:

> Foster Family participation in 76% of the meetings,
> Children (11+) attended 46% of the meetings, and
> Parent(s) participated in 57%

A factor that was taken into consideration when examining participation of family foster care permanency planning meetings pertained to the age of many of the children. The North Dakota Department of Human Services Manual (1990, p. 13) stated that it may be appropriate to exclude any person from the permanency planning meeting when good cause exists. Based on the age of many of the children in family foster care, a required age of 11 was established by this author. Cases in which the child was younger than 11 were not included when measuring child participation in family foster care permanency planning meetings.

Appendix F contains the visual data comparing residential child care to family foster care participation at permanency planning meetings. When examining the results, family foster care maintains an overall higher percentage of attendance at permanency planning meetings. However, family foster care homes are located in the county or community where the permanency planning meeting takes place. When comparing the percentage of attendance of residential providers that are in the same community, the participation percentage exceeds the family foster care provider.

Results for Objective Five

> Objective Five: Identify specific expenses, time considerations, and other factors involved with attendance at permanency planning meetings.

Completing objective five required recording on the information form and using previous findings in calculations. The information form recorded the number of professionals attending the permanency planning meetings. Findings indicated that the meetings included from two to as many as 11 professionals. North Central's average (mean) was 6.1 and the mode equaled six professionals per meeting. Southeast's average (mean) was

4.8 and the mode equaled four professionals per meeting. The two regions combined for a meeting average of 5.3 professionals in addition to the family, child, and foster care provider. In addition to the regional supervisors, the professionals in attendance included staff from: Juvenile Courts, educational districts, county social services, law enforcement, independent living programs, private agencies, community based services, and therapy staff from the human service center. This author encouraged consideration for the costs and salaries that mount if professionals are present but key participants (family, child, and foster care provider) are not involved.

Using the identified average distance of 152 miles that a child and residential provider was from the permanency planning meeting, the following illustrate the requirements (factors) for participation.

-Travel costs - .29 x 152 mile x 2 (round-trip) = $88.16

-The salaries of two staff to accompany = $156.00 (estimated)

-Meals = $18.00

-Travel time - 5.5 hours

-In 96 of the residential provider/permanency planning meetings, lodging expenses would be required as travel distance/time would be

too great. In such cases, the other identified expenses would be increased significantly.

Results for Objective Six

Objective Six: Gather data identifying the number of permanency planning sites with speaker phone/conference call capabilities.

Completing objective six required a different solution approach from the previous objectives as the collection of data was based on a phone interview with regional supervisors. The questions that were solicited were, "How many of the permanency planning meeting sites have conference call capabilities?"

Some difficulties were experienced in completing this objective. They included: problems contacting the regional supervisors due to their schedules, leave, and responsibilities, and the survey question was inadequate which led to ambiguous responses. The modifications included contacting and questioning other representatives who participated in the regional permanency planning meetings and subsequent questions to

interpret the responses.

Of the 53 sites where permanency planning meetings are conducted, the results were obtained are as follows:

-22 sites had speaker phone/conference call systems functioning in the area where the meeting was held.

-18 locations indicated that conference call systems are available, but their meetings are not always conducted in the location of the speaker phone/conference call system.

-13 sites indicated that conference call systems were not in operation and/or if they were to furnish a conference call they would have to coordinate the meeting at another location or possibly a smaller office.

This author stressed the difficulties experienced when collecting the aforementioned information. Concerns are noted over the exact accuracy of the findings. However, it is important to stress that the findings do indicate that conference call systems are not readily available at all permanency planning sites.

Chapter Six

Conclusions and Recommendations

In chapter five, an ample amount of information was provided. Over 2,600 files were reviewed resulting in data being abstracted from over 620 permanency planning 1993 records. Some findings collected and considered most significant include:

-Residential child care providers and children in care participated in 30% of all permanency planning meetings conducted in the state.

-When residential child care centers are within 30 miles of the permanency planning meeting, the percentage of participation was at 86%. Participation was only 16% when the meeting is beyond 30 miles from the center.

-Although there were differences in the percentages of attendance at permanency planning among North Dakota's residential child care providers, face-to-face involvement was problematic for all providers when the meeting was not conducted in the location of the center.

-One small center maintained the highest percentage of involvement with the evaluated regions by conference call interactions.

-The percentage of participation of children in residential care was consistent with the percentage of the provider.

-Of the two surveyed regions, the average distance a child was placed from his home when in residential care was 152 miles. Seventy-four percent of the children (220 out of 294 residential placements) were not placed near their home, and in 129 of the residential reviews, the child was over 200 miles from his home.

-Family foster care was typically in close proximity to the meetings and maintains an overall higher percentage of attendance. When comparing the percentage of attendance of residential providers that are in the same community, the participation percentage of residential care exceeded the family foster care provider.

-Speaker phone/conference call systems are accessible; however, conference call systems were not readily available at all permanency planning sites.

When the aforementioned findings are merged with the points which emphasized the importance of permanency planning, family centered programming, maintaining parental and family ties, community connections, social support networks, coordination and collaboration of efforts, involvement in planning, and community reintegration, it is increasingly important that action be taken to increase participation in permanency

planning meetings.

As indicated, the primary goal of the project was to propose solution strategies. There are reasonable actions to address the identified concerns, and the identified solutions have been further supported within the findings. The focus on the solution strategy was not to direct blame, but to identify changes the involved participants can make to effectively resolve the deficiencies and improve the process.

The proposed solution strategy can be immediately initiated to increase the use of conference call systems. With the combined efforts of residential providers, court appointed custodians (Division of Juvenile Services and county social services), and the regional supervisors of the Department of Human Services, conference call permanency planning meetings could be regularly executed when face-to-face involvement is not feasible. This author continued to support that face-to-face contact/involvement should be the principal manner in which permanency planning meetings are conducted. However, when face-to-face involvement was not an option, conference call permanency planning meetings should be the next means to ensure that the key parties are involved, promoting

the pro-family philosophy.

Previously time-management, conflicting responsibilities, distance, lack of sufficient notification, and costs and expenses were identified as some of the principal difficulties that interfered with permanency planning participation. The access of conference call involvement would alleviate many of these issues. Some benefits to utilizing conference calls require minimal arrangements and time, lessening the prior concerns. Costs can be significantly decreased. Using the identified average distance of 152 miles that a child and residential provider are from the permanency planning meeting, the following would illustrate the costs of a conference call.

-The costs of a direct dial conference call is 24 cents for the first minute and 18 cents each additional minute. Expenditures for a one hour call from the residential setting to the permanency planning meeting would be $10.86, based on current long distance rates of AT&T. Rates may vary dependent on the long distance carrier.

-An operator assisted conference call is 53 cents per line, per minute. An additional $4.00 per line charge is applied. The projected costs for a conference call involving three sites would be $71.60.

Two additional factors that should also be considered are weather conditions and the child's absenteeism from school. Weather/travel conditions can be unpredictable in North Dakota. Conference calls could be utilized in the winter months when weather interferes with travel. A final factor was the concern of a child being absent from school. Many of the children in residential care are experiencing educational difficulties and their being absent from school for extended periods of time may risk advancement. Missing one to two hours to participate in the conference call would be less detrimental than missing up to two days of school to participate in the permanency planning meeting. However, the child still would remain involved in the planning process and remain connected with the community.

Conference call implementation does appear to be a valuable alternative, but there are responsibilities and actions that will be necessary if they are to be used.

-A responsibility of the Department of Human Services will be to assure that conference call systems are established and accessible at all permanency planning sites. Regional supervisors who oversee the permanency planning meetings should be educated and

encouraged to promote conference call involvement when personal attendance is not feasible.

-A responsibility of the residential provider is to take responsibility to request and promote conference call involvement when face-to-face interactions are not possible.

-A responsibility of this author is to begin dispersing the findings and to promote the identified solution strategy. Objectives seven, eight, and nine have identified three strategies to present the findings to professional colleagues, assemblies, and organizations.

-Objective seven: The findings and solution strategy will be presented at the primary practicum setting to the social service and quality assurance committees.

-Objective eight: The results of this project, the findings, and solution strategy will be provided to the Department of Human Services, Children and Family Services Division. (This was also an agreement that was made when the project was initiated.)

-Objective nine: The results, findings, and solution strategy will be presented to North Dakota's Coalition of Residential Providers. (The initiation of the project was reviewed in

September 1994, and interest in the findings was indicated.)

Although this author feels conference call activities are the most feasible solution when face-to-face involvement is not possible, alternative options and solutions should continue to be considered and explored. A technology that is currently accessible on a limited basis throughout the entire state is two-way interactive video telecommunications. The two-way video systems transmit live, high quality audio and color video between sites. The system is voice activated. Participants are able to hear and see other participants at joining sites. Currently, the system links North Dakota's public colleges and universities and the state capitol as 20 sites have been established. The cost to access the system is $95.00 per hour for line charges and $20.00 per hour, per site, for technical support.

The prospect of interactive video telecommunications being used for permanency planning could be a better alternative than conference calls, but sites are limited and occupied for educational and government purposes. This author anticipates possibilities and believes it may be a valuable asset to be considered in collaboration and pro-family interactions as sites increase.

This author believes follow-up studies would be beneficial at a state and agency level. Recommendations would be for large studies to occur one year after solution strategies have been presented and/or other solutions have been implemented to increase permanency planning involvement. If future research is conducted at a state level, recommendation are to examine attendance in all regions using a statistically sound process.

An agency/provider level follow-up should involve the establishment of an internal monitoring process. At the primary practicum setting, it is advised the agency's participation in permanency planning meetings be monitored through the quality assurance/improvement program. Specifically under the social service department.

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APPENDIX A

PERMANENCY PLANNING FORM

SFN 624-1SS/903

PERMANENCY PLANNING COMMITTEE INITIAL REPORT

N.D. Department of Human Services/CFS
SFN 624-1SS/902 (Rev. 10-90)

DATE COMPLETED		
Month	Day	Year

1.

Name of Child	Child's Social Security No.	BIRTHDATE Month	Day	Year

Case Manager	Sex Code	Race Code

Matching Symbol	County Case Number	Region	Natural Family Size Adults	Children

Initial Clinically Diagnosed Disabling Condition: ☐ Yes (Check As Many As Apply) ☐ No

____ 01 Mental Retardation	____ 04 Hearing, Speech or Sight Impairment	____ 07 Other Clinical Diagnosed Conditions
____ 02 Emotional Disturbance	____ 05 Physical Disability	____ 08 Other Non-Clinical Problem(s) Precipitating Problems
____ 03 Specific Learning Disability	____ 06 Developmentally Disabled	____ 09 Runaway

2. Use County Codes

Physical Presence County	Legal (Custodial) County or	Administrative Responsibility Co.

DJS _____ Exec. Dir. _____

3. **Primary Reason For Foster Care (Check Either "A" or "B")**

____ A. Parent/Caretaker Unable to Cope With Child's Conduct or Condition

- ____ 01 Delinquent
- ____ 02 Unruly
- ____ 03 Deprived
- ____ 77 Child Disability or Handicap
- ____ 78 Other Child-Related Conduct or Condition (Explain) _____

____ B. Parent/Caretaker Conduct, Condition or Absence

- ____ 03 Indicated Report of Child Abuse
- ____ 04 Indicated Report of Child Neglect
- ____ 05 Indicated Report of Sexual Abuse
- ____ 06 Other Family Interaction Problems
- ____ 07 Housing or Financial Hardship
- ____ 08 Parent/Caretaker Illness, Disability or Substance Abuse
- ____ 09 Parent/Caretaker Temporary Absence
- ____ 10 Parent/Caretaker Death
- ____ 11 Relinquishment of Parental Rights
- ____ 88 Other Parent/Caretaker-Related Conduct, Condition or Absence

4. Briefly Explain the Reason for and Appropriateness of the Placement

4a. Emergency Placement? ☐ Yes ☐ No

5. **Attempts to Prevent Placement (List As Many Codes As Needed Up To Five)**

6. **Foster Care Entry and Discharge Date(s) (List Most Current At Top)**

ENTRY Month	Day	Year	DISCHARGE Month	Day	Year	PROVIDER: Name and Address	Facility Code

TPR ☐ Yes ☐ No ☐ Voluntary ☐ Involuntary

TPR Date | | | | | | |

Custodian

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CODE INFORMATION

RACE CODES
(Section 1)

01 White
02 American Indian
03 Black
04 Asian
05 Hispanic
06 Southeast Asia

MATCH SYMBOLS
(Section 1)

01 FM
02 FM IND
03 REG
04 IND
05 SA-FM
06 SA-FM IND
07 SA-REG
08 SA-IND

MARITAL STATUS
(Question 17)

01 Married, living together
02 Married, not living together
03 Father dead
04 Mother dead
05 Both parents dead
06 Not married
07 Divorced
08 Other

SEX CODES
(Section 1)

01 Male 02 Female

PREVENT PLACEMENT CODES
(Question 5)

01 Parenting Skills Training
02 Protective Service Counseling
03 Homemaker-Home Health Aide Services
04 Day Care
05 Budgeting
06 Job Counseling
07 Vocational Rehabilitation
08 Financial Planning
09 Housing Assistance
10 Mental Health Services
11 Drug and Alcohol Counseling
12 Medical Services and Consultation
13 Nursing Service
14 Self Help Groups
15 Legal Assistance
16 Respite/Relief Care
17 School Counseling
18 Recreation for Children
19 Psychological/Psychiatric Evaluation and Services
20 Parent-Aide Program
21 Neighbors Program
22 Other (Specify)

COURT ORDERS
(Question 16)

Court Type

01 Juvenile Court
02 District Court
03 Tribal Court
04 Legal Custodian (DJS)

Court Orders (Type)

01 Temporary
02 Dispositional
03 Extended
04 TPR

FACILITY CODES
(Question 6)

Family Foster Care

01 Family Foster Care Home

Group Home Codes

10 Charles Hall Youth Services
11 Eckert Youth Homes
12 Independence Inc.
13 Harvey Group Home
14 Harmony House
15 Other

Residential Child Care Facility Codes

30 Home on the Range for Boys
31 Dakota Boys Ranch RCCF
32
33
34
35 Pierre Learning Center
36
37
38 New Beginnings Center
39
40 New Connections
41 St.Cloud Children's Home
42 Jamestown (MN) Treatment Ctr.
43 Bar-None (MN) RTC
44 Other

Residential Treatment Center Codes

50 Ruth Meiers
51 Manchester
52 Luther Hall RTC
53 River's Edge
54 Dakota Boys Ranch RTC
55 Other

REUNITE CODES
(Question 15)

01 Parenting Skills Training
02 Protective Service Counseling
03 Homemaker-Home Health Aide Services
04 Day Care
05 Budgeting
06 Job Counseling
07 Vocational Rehabilitation
08 Financial Planning
09 Housing Assistance
10 Mental Health Services
11 Drug & Alcohol Counseling
12 Medical Services Consultation
13 Nursing Service
14 Self Help Groups
15 Legal Assistance
16 Respite/Relief Care
17 School Counseling
18 Recreation for Children
19 Psychological/Psychiatric Evaluation and Services
20 Parent Aide Program
21 Neighbors Program
22 Other (Specify)

Child's Name	Date

7. **Procedural Safeguards:**

A. Were Parents/Guardians Notified in Writing of the Removal of the Child from Their Home? Yes _____ No _____

If No, Check Reason(s) Below:

_____ 01 Deceased
_____ 02 Whereabouts Unknown
_____ 03 Court Did Not Inform Them
_____ 04 Other (Explain) _____

B. Were Parents/Guardian Notified in Writing of Their Visitation Rights? Yes _____ No _____

If No, Check Reason(s) Below:

_____ 01 Deceased
_____ 02 Whereabouts Unknown
_____ 03 Other (Explain) _____

C. Were Parents/Guardian Notified in Writing of Any Change in the Child's Placement? Yes _____ No _____

If No, Check Reason(s) Below:

_____ 01 Deceased
_____ 02 Whereabouts Unknown
_____ 03 Other (Explain) _____

8. **Did the Parents/Guardian, Child (When Appropriate), Foster Family/Facility and Agency Develop a Written Agreement for the Placement of the Child?**

Yes _____ No _____

9. **Were the Following People Invited in Writing to Attend the Permanency Planning Meetings?**

Natural Parents/Guardians Yes _____ No _____
Foster Parent(s) Yes _____ No _____
Child, Where Appropriate Yes _____ No _____

10. **If the Placement is NOT in a Family Foster Home, Explain Why by Checking One:**

_____ 01 No foster home available
_____ 02 Child Refused to be in Family Care
_____ 03 Parent Refused to Have Child in Family Care
_____ 04 Attempted Family Placement & Didn't Work
_____ 05 Child Placed in Group Care Due to Need for Structured Environment
_____ 06 Family Home not Appropriate for Child
_____ 07 Other (Explain) _____

11. **If Child is Placed Outside of His/Her Own County, Explain Why by Checking One:**

_____ 01 Child in Danger from Parent(s)
_____ 02 Resources for Child not Available in Own County
_____ 03 Child Wanted to be Further Away from Home
_____ 04 Parent(s) Wanted Child in Another Community
_____ 05 Court Wanted Child in Another Community
_____ 06 Other (Explain) _____

12. **Current Case Plan Goal (Check One)**

✓	CASE PLAN GOAL	Proposed Accomplished Date			Actual Accomplished Date		
		Month	Day	Year	Month	Day	Year
	01 Return Child to Own Home	/	/	/	/	/	/
	02 Place with Relatives	/	/	/	/	/	/
	03 Place for Adoption	/	/	/	/	/	/
	04 Long Term Foster Care	/	/	/	/	/	/
	05 Place with Legal Guardian(s) or Caretaker	/	/	/	/	/	/
	06 Independent Living	/	/	/	/	/	/
	07 Goal is Pending (Explain)	/	/	/	/	/	/
	08 Other (Explain)	/	/	/	/	/	/

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Child's Name	Date

13 **INDEPENDENT LIVING PLAN:**

Where appropriate, for a child age 16 or over, the case plan must also include a written description of the programs and services which will help such child prepare for the transition from foster care to independent living. (Based on assessment of child's needs.)

a. Youth's Involvement in Planning:

b. Youth's Involvement With/Of Natural Family (Extended family also):

c. Educational/Vocational

Current Educational Status:

1._____ highest grade completed
2._____ in high school
3._____ in alternative school
4._____ working on GED

Plan For Continued Education

d. Employment Plan:

e. Assessment of Daily Living Skills:

f. Planned Living Arrangement:

g. Support System Available to Youth:

h. Barriers to Independent Living Plan:

i. Identify Specific IL Services to be Offered to Achieve IL Plan:

Child's Name	Date

4. **CASE PLAN:** Specify the written agreement to achieve the goal checked in Item 12 through identifying the task(s) of those listed below and the estimated time frame for accomplishment: Explain how the tasks are appropriate for the family and facilitate the goal. If more space is needed, copy this sheet and attach as needed.

TASK	Explain How Task is Appropriate for Family & Facilitates Goal	Estimated Time Frame		
		Month	Day	Year
14 a. Natural Parents/Guardian				
14 b. Foster Child				
14 c. Foster Parents				
14 d. Agency				

Child's Name	Date

14. EDUCATION AND HEALTH INFORMATION

Every child's foster care case plan must include health and education records, to the extent available and accessible, as follows:

COMPLETE ALL BLANKS

14e. EDUCATION • The names and addresses of the child's educational providers:	**14f. HEALTH** • The names and addresses of the child's health providers:
• The child's grade level performance:	• A record of the child's immunizations:
• The child's school record: (attach additional pages as needed)	• The child's known medical problems:
• Assurances that the child's placement in foster care takes into account proximity to the school in which the child is enrolled at the time of placement: (explain)	• The child's medications:
• Any other relevant eduction information concerning the child determined to be appropriate by the state agency: Date of IEP _____ Other:	• Any other relevant health information concerning the child determined to be appropriate by the state agency: • DATE OF EPSDT Screening_____ • Known Allergies _____

Child's Name	Date

15 What Services Will be Provided in an Attempt to Reunite This Child With His/Her Family or Develop Some Other Type of Permanent Plan? (List from Reunite Code Table)

16. Court Order(s): List Most Current At Top

Court* Type	Type of Court Order	Date			Expiration Date(s)			Comments
		Month	Day	Year	Month	Day	Year	

* Juvenile Court (JC) District Court (DC) Tribal Court (TC) Legal Custodian (DJS)

17.

Name of Parent(s)/Guardian	
Parent's Address	
Phone	Marital Status

Child's Name	Date

18.

Agency Providing Services to Child
Agency Providing Services to Parents

19. Persons Attending Initial Permanency Planning Committee Meeting. (Check as Many as Needed)

✓	CODE	SIGNATURES OF PERSONS ATTENDING	DATE
	01 Regional Supervisor		
	02 County/Agency Supervisor		
	03 Case Manager/Caseworker		
	04 Youth in Care		
	05a Parent/Guardian		
	05b Parent/Guardian		
	06a Foster Parent		
	06b Foster Parent		
	07 Juvenile Court Personnel		
	08 School Personnel		
	09 Medical Personnel		
	10 DJS Representative		
	11 Other		
	12 Other		

20. Is Everyone in Agreement with the Plan? ☐ Yes ☐ No If No, Explain:

21. Next Permanency Planning Committee Review Date:

Month	Day	Year

DISTRIBUTION:	COPIES MUST BE MADE AND DISTRIBUTED TO:
Original - CFS Canary - HSC (Physical County of Child) Pink - CSSB (Legal)	- CSSB (Administrative) - CSSB (Physical) - HSC in Admin. County of Child - Court - Natural Parent/Guardian - Foster Parent/Facility - Child - (when appropriate) - DJS

This form must be completed at least every three (3) months during the first two (2) years of the child's placement and at least every six (6) months thereafter. A copy of this form must be given to the parent(s)/guardian upon completion.

APPENDIX B

PERMANENCY PLANNING FORM

SFN 624-2SS/902

PERMANENCY PLANNING COMMITTEE PROGRESS REPORT

N.D. Department of Human Services/CFS
SFN 624-2SS/903 (Rev. 10-90)

DATE COMPLETED		
Month	Day	Year

1.

Name of Child	Child's Social Security No.	BIRTHDATE Month	Day	Year
Case Manager	County Case Number			

Is The Placement Outside of The Home Still Necessary and Appropriate? _____ Yes _____ No If Yes, Explain Circumstances:

Use County Codes:

Physical Presence County	Legal (Custodial) County or	Administrative Responsibility Co.
	DJS _____ Exec. Dir. _____	

Additional Clinically Diagnosed Disabling Condition: ☐ Yes (Check As Many As Apply) ☐ No

_____ 01 Mental Retardation
_____ 02 Emotional Disturbance
_____ 03 Specific Learning Disability
_____ 04 Hearing, Speech or Sight Impairment
_____ 05 Physical Disability
_____ 06 Developmentally Disabled
_____ 07 Other Clinical Diagnosed Conditions
_____ 08 Other Non-Clinical Problem(s) Precipitating Placement
_____ 09 Runaway

2. **Date Child Left Foster Care** (On date child leaves foster care, complete final SFN 624-2/903 and indicate date child left and reason. Leave this iter blank if child is still in foster care.)

Month	Day	Year

3. **Placement Changes and Dates: Please Complete Information Below. (Most Recent at Top.)**

Date of Change			Discharge			Provider Name and Address	Facility Code
Month	Day	Year	Month	Day	Year		

Briefly Explain The Reason For The Change And Appropriateness of The New Placement.

4. A. Were The Following People Invited In Writing, To Attend The Permanency Planning Meeting?

_____ Yes _____ No Natural Parent/Guardian
_____ Yes _____ No Foster Parent(s)
_____ Yes _____ No Child (Where Appropriate)

B. Were Parents/Guardian Notified, in Writing, of Their Visitation Rights? ___ Yes ___ No
If No, What Reason(s)? (Check Below)

_____ 01 Deceased
_____ 02 Whereabouts Unknown
_____ 03 Other (Explain) _____

C Were Parents/Guardian Notified, in Writing, of Any Change in the Child's Placement? ___ Yes ___ No ___ N/A (no change placement)
If No, What Reason(s)? (Check Below)

_____ 01 Deceased
_____ 02 Whereabouts Unknown

CODE INFORMATION

FACILITY CODES
(Question 3)

Family Foster Care

01 Family Foster Care Home

Group Home Codes

10 Charles Hall Youth Services
11 Eckert Youth Home
12 Independence Inc.
13 Harvey Group Home
14 Harmony House
15 Other

Residential Child Care Facility Codes

30 Home on the Range for Boys
31 Dakota Boys Ranch
35 Pierre Learning Center
38 New Beginnings Center
40 New Connections
41 St. Cloud Children's Home
42 Jamestown (MN) Treatment Ctr.
43 Bar-None (MN) RTC
44 Other

Residential Treatment Center Codes

50 Ruth Meiers
51 Manchester
52 Luther Hall RTC
53 River's Edge
54 Dakota Boys Ranch RTC
55 Other

Child's Name	Date

5. Current Case Plan Goal (Check One)

✓	CASE PLAN GOAL	Proposed Accomplished Date			Actual Accomplished Date		
		Month	Day	Year	Month	Day	Year
	01 Return Child to Own Home						
	02 Place with Relatives						
	03 Place for Adoption						
	04 Long Term Foster Care						
	05 Place with Legal Guardian(s) or Caretaker						
	06 Independent Living						
	07 Goal is Pending (Explain)						
	08 Other (Explain)						

Comments

6.

Every child's foster care case plan must include health and education records, to the extent available and accessible. Enter below changes and updates to health and education information.

EDUCATION

- The names and addresses of the child's educational providers:
- The child's grade level performance:
- The child's school record: (attach additional pages as needed)
- Assurances that the child's placement in foster care takes into account proximity to the school in which the child is enrolled at the time of placement: (explain)
- Any other relevant eduction information concerning the child determined to be appropriate by the state agency:

Date of IEP _____

Other:

HEALTH

- The names and addresses of the child's health providers:
- A record of the child's immunizations:
- The child's known medical problems:
- The child's medications:
- Any other relevant health information concerning the child determined to be appropriate by the state agency:
  - DATE OF EPSDT Screening _____
  - Known Allergies _____

BEST COPY AVAILABLE

Child's Name	Date

INDEPENDENT LIVING PLAN:

Where appropriate, for a child age 16 or over, the case plan must also include a written description of the programs and services which will help such child prepare for the transition from foster care to independent living. (Based on assessment of child's needs.)

a. Youth's Involvement in Planning:

b. Youth's Involvement With/Of Natural Family (Extended family also):

c. Educational/Vocational

Current Educational Status:

1._____ highest grade completed
2._____ in high school
3._____ in alternative school
4._____ working on GED

Plan For Continued Education

d. Employment Plan:

e. Assessment of Daily Living Skills:

f. Planned Living Arrangement:

g. Support System Available to Youth:

h. Barriers to Independent Living Plan:

i. Identify Specific IL Services to be Offered to Achieve IL Plan:

Child's Name	Date

8. **CASE PLAN PROGRESS REPORT:** List accomplishments from previous permanency planning meetings and list new tasks to be completed and time frames. Explain how the tasks are appropriate for the family and facilitate the goal (from Item No. 5). If more space is needed, copy this sheet and attach as needed.

TASK	COMMENTS	Estimated Time Frame		
		Month	Day	Year
8 a. Natural Parents/Guardian				
8 b. Foster Child				
8 c. Foster Parents				
8 d. Agency				

Child's Name	Date

9. Persons Attending Permanency Planning Committee Meeting. (Check as Many as Needed)

✓	CODE	SIGNATURES OF PERSONS ATTENDING	DATE
	01 Regional Supervisor		
	02 County/Agency Supervisor		
	03 Case Manager/Caseworker		
	04 Youth in Care		
	05a Parent/Guardian		
	05b Parent/Guardian		
	06a Foster Parent		
	06b Foster Parent		
	07 Juvenile Court Personnel		
	08 School Personnel		
	09 Medical Personnel		
	10 DJS Representative		
	11 Other		
	12 Other		

10. Is Everyone in Agreement with the Plan? ☐ Yes ☐ No If No, Explain:

11. Court Order (Most Recent)

Court* Type	Type of Court Order	Date Month	Date Day	Date Year	Expiration Date Month	Expiration Date Day	Expiration Date Year	Comments

* Juvenile Court (JC) District Court (DC) Tribal Court (TC) Legal Custodian (DJS)

12. Next Permanency Planning Committee Review Date:

Month	Day	Year

DISTRIBUTION:	COPIES MUST BE MADE AND DISTRIBUTED TO:
Original - CFS Canary - HSC (Physical County of Child) Pink - CSSB (Legal)	- CSSB (Administrative) - CSSB (Physical) - HSC in Admin. County of Child - Court - Natural Parent/Guardian - Foster Parent/Facility - Child - (When Appropriate) - DJS

This form must be completed at least every three (3) months during the first two (2) years of the child's placement and at least every six (6) months thereafter. A copy of this form must be given to the parent(s)/guardian upon completion.

APPENDIX C

INFORMATION FORM

PERMANENCY PLANNING INFORMATION FORM

Region - NC - SE

1. Is the child placed in residential foster/group care? Yes No

   If in family care is the child younger than eleven _____ Yes

   a. If placed in residential care, what is the facility?

CHYS	TDC-F	TDC-M	EYH	HARM	HOTR
LIT-F	LUT-H	MAN	NEW-O	PLC	RIV-E
RM	OTHER_____		FAM/FOST LOCATION_____		

   b. Where was the permanency planning meeting conducted?

   _____

   c. How many miles away is the residential facility from the community where the permanency planning meeting was held? _____

   The number of professionals attending? _____

2. Did a representative of the residential setting participate in the permanency planning meeting? Yes No

3. Did the child attend/participate in the permanency planning meeting? Yes No

4. Did a family member attend/participate in the permanency planning meeting? Yes No

APPENDIX D

PRACTICUM IMPLEMENTATION PLAN

Implementation Plan

All the activities outlined in the plan of implementation and identified weeks was conducted and coordinated by the author.

Week One. The following are the essential activities that were completed during week one of the practicum project:

1). Notification of the North Dakota Department of Human Services, Management Services Director and Child and Family Services Director, that approval was secured to proceed with the project and records examination.

2). Contacted the North Central Human Service Center Program Director and arranged site visitation dates to review 1993 permanency planning reports from this region.

3). Contacted the Southeast Human Service Center Program Director and arranged site visitation dates to review 1993 permanency planning reports from this region. Reverification of project approval was requested by the center director. Projected time of record review was to be two days.

Week Two. The following essential activities were completed during week two of the practicum project:

1). Verification of information provided to Southeast Human Service Center. Approval for site verification secured.

2). Following the arrangement of Human Service Center site visitation, (Southeast and North Central Human Service Centers) vacation time was coordinated with supervisor.

3). Lodging arrangements were made for the site visitation at the Southeast Human Service Center in Fargo, North Dakota. Reservations were confirmed for two nights.

4). Reproduced and completed 300 copies of the permanency planning information form which was used for data collection at the human service centers.

Week Three. The following essential activities were completed during week three of the practicum project:

1). Coordinated and completed vehicle maintenance with an automobile service center in preparation for travel requirements to visit the human service center(s) for data collection.

2). Sent out letters to the regional program directors confirming dates of site visitation.

Week Four. The following essential activities were completed during week four of the practicum project:

1). Site visitation at North Central Human Services for review of 1993 permanency planning records. Time of data collection was ten hours. No travel time was required, as the center was located in close proximity to the primary practicum setting.

2). Reproduced 400 additional copies of the permanency planning information form which was used for data collection at site two (Southeast Human Service Center).

Week Five. The following activities were completed during week five of the practicum project:

1). Travel from Minot, North Dakota, to Fargo, North Dakota. Total miles one way equaled 306. Travel occurred by car and travel time was five hours one way, including food and rest stops.

2). Site visitation at Southeast Human Services for review of 1993 permanency planning records. Time of data collection was two days.

3). Return travel from Fargo, North Dakota, to Minot, North Dakota.

Week Six. The following activities were completed during week six of the practicum project:

1). Composed and sent letters thanking the North

Central/Southeast Human Service Centers Program Directors for allowing and assisting in the practicum project.

2). Began computing and analyzing the permanency planning information forms and collected data.

Week Seven. The following activities were conducted during week seven of the practicum project:

1). Analyzed the collected data and began computation of findings, specifically acquiring results surrounding:

a). The percentage of children, families, and residential child care providers who participated in permanency planning meetings conducted in North Dakota during the year of 1993.

b). Obtained data identifying the distance between permanency planning meetings and the placement of the child.

2). Attempted contact with the eight regional supervisors who chair the permanency planning meetings in each region. Information was collected in regards to conference call capabilities in each human service region. Specifically identifying the number of permanency planning sites in the region with conference call capabilities.

Week Eight. The following activities were conducted during week eight of the practicum project:

1). Based on obligations and schedules of the regional supervisors, communication with them was extended to week eight. Continued efforts for information collection in regards to conference call capabilities within each human service region/county sites.

2). Analyzed the collected data and began computation of findings, specifically acquiring results surrounding specific data to compare the 13 residential care providers of North Dakota participation in permanency planning meetings.

Week Nine. The following were the essential activities completed during week nine of the practicum project:

1). Based on obligations and schedules of the regional supervisors, contact was made with other representatives who participate in the regional permanency planning meetings.

2). Calculated findings from the regional supervisors and regional representatives surrounding conference call capabilities throughout the state.

3) Completed data examination and began to survey and evaluate possible solution strategies.

Week Ten. The following essential activities were completed during week ten of the practicum project:

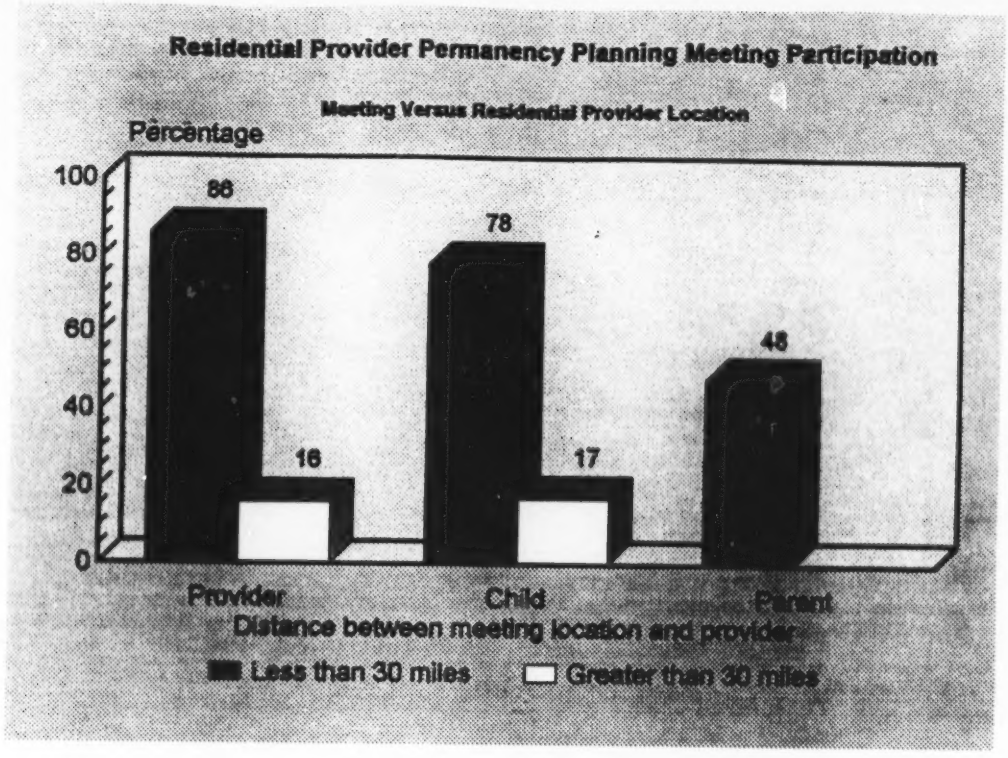
1). Concluded examination and identification of proposed/potential solution strategy.

2) Designed materials which visually demonstrated findings and detailed how solution strategies could be implemented. Graphic Impact was used to visually expand ideas and suggested solution strategies of the author.

3). Began preparations for proceeding with the practicum report to fulfill practicum requirements.

APPENDIX E.

RESIDENTIAL/CHILD PARTICIPATION AT PERMANENCY PLANNING BASED ON DISTANCE



The above bar graph demonstrates how residential provider and child participation decreases when the permanency planning meeting is conducted greater than 30 miles from the treatment center. The meeting is conducted near the residence of the parent, so no comparison is made pertaining to the parent.

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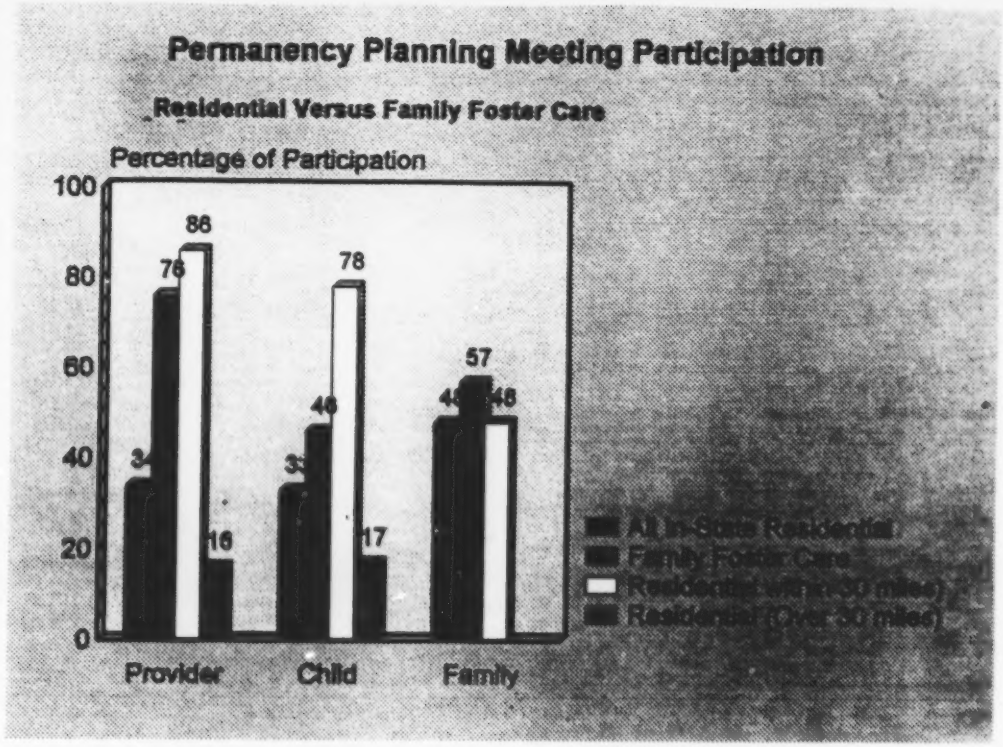
APPENDIX F

RESIDENTIAL CHILD CARE/FAMILY FOSTER CARE

ATTENDANCE AT PERMANENCY PLANNING MEETINGS



The bar graph compares permanency planning meeting attendance of residential child care providers to family foster care. Family foster care homes were found to be in close proximity of the permanency planning meeting. It also compares attendance examining the difference in residential provider attendance when the center is within or greater than 30 miles from the permanency planning site.

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